		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040402

Facility Name: IMPERIAL OF HAZEL CREST

Address: 3300 W. 175TH STREET (Number) HAZEL CREST (City) 60429 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3873064

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,006	4,006	8
9	SNF/PED					9
10	ICF	40,208	1,793		42,001	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,208	1,793	4,006	46,007	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 3,987

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,052	30,907	11,977	218,936		218,936	2,578	221,514			1
2	Food Purchase		188,413		188,413	(19,874)	168,539	(902)	167,637			2
3	Housekeeping	144,568	25,656		170,224		170,224		170,224			3
4	Laundry	50,260	13,396		63,656		63,656		63,656			4
5	Heat and Other Utilities			152,166	152,166		152,166	175	152,341			5
6	Maintenance	46,638	22,129	38,184	106,951		106,951	4,685	111,636			6
7	Other (specify):*			63,125	63,125		63,125		63,125			7
8	**TOTAL General Services**	417,518	280,501	265,452	963,471	(19,874)	943,597	6,536	950,133			8
	B. Health Care and Programs											
9	Medical Director			1,600	1,600		1,600		1,600			9
10	Nursing and Medical Records	1,306,692	52,169	4,690	1,363,551		1,363,551	24,891	1,388,442			10
10a	Therapy	38,383	1,517	48,789	88,689		88,689	(1,979)	86,710			10a
11	Activities	67,984	13,221	1,202	82,407		82,407		82,407			11
12	Social Services	160,671		864	161,535		161,535		161,535			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,573,730	66,907	57,145	1,697,782		1,697,782	22,912	1,720,694			16
	C. General Administration											
17	Administrative	121,173			121,173		121,173	54,246	175,419			17
18	Directors Fees											18
19	Professional Services			160,871	160,871		160,871	(10,975)	149,896			19
20	Dues, Fees, Subscriptions & Promotions			30,427	30,427		30,427	(2,159)	28,268			20
21	Clerical & General Office Expenses	140,277	15,319	175,897	331,493		331,493	(91,388)	240,105			21
22	Employee Benefits & Payroll Taxes			342,479	342,479	19,874	362,353		362,353			22
23	Inservice Training & Education			2,242	2,242		2,242	732	2,974			23
24	Travel and Seminar							657	657			24
25	Other Admin. Staff Transportation			2,345	2,345		2,345	2,440	4,785			25
26	Insurance-Prop.Liab.Malpractice			123,325	123,325		123,325	2,545	125,870			26
27	Other (specify):*							36,127	36,127			27
28	**TOTAL General Administration**	261,450	15,319	837,586	1,114,355	19,874	1,134,229	(7,775)	1,126,454			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,252,698	362,727	1,160,183	3,775,608		3,775,608	21,673	3,797,281			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: IMPERIAL OF HAZEL CREST #0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		4,777	
			0	11,977
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		53,567	
	ELECTRICITY		53,750	
	WATER		44,849	
	CABLE TV - LOBBY		0	
			0	152,166
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,548	
	PAINTING & DECORATING		2,594	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,205	
	ELEVATOR MAINTENANCE & REPAIR		3,702	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,345	
	FIRE SERVICE		5,790	
			0	
			0	
			0	38,184
7	**OTHER**			
	SCAVENGER		10,180	
	SECURITY SERVICE		52,945	63,125
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,600	1,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		345	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,720	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		2,625	
			0	4,690
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		7,641	
	SPEECH THERAPY SERVICES		459	
	OCCUPATIONAL THERAPY SERVICES		5,774	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	20,515	48,789
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,202	
				1,202
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	864	
			0	864
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number IMPERIAL OF HAZEL CREST **#0040402** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,008	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	136,863	
			0	160,871
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,297	
	EMPLOYEE WANT ADS	XIX F	6,551	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	11,309	
	LICENSES & PERMITS	XIX F	4,812	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,308	30,427
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		999	
	EQUIPMENT REPAIR & MAINTENANCE		6,363	
	OUTSIDE CLERICAL SERVICES		122,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	19,376	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		598	
	TELEPHONE		23,943	
	MESSENGER SERVICE		2,218	
			0	175,897

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	170,075	
	UNEMPLOYMENT COMPENSATION	XIX D	28,778	
	WORKERS COMPENSATION INSURANCI	XIX D	35,309	
	HOSPITALIZATION INSURANCE	XIX D	85,850	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,939	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	20,528	
	CHICAGO HEAD TAX	XIX D	0	342,479
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,242	2,242
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,345	2,345
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		123,325	123,325
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,160,183

Facility Name & ID Number IMPERIAL OF HAZEL CREST #0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,277	51,277		51,277	(17,215)	34,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			224,597	224,597		224,597	38,284	262,881			32
33	Real Estate Taxes			380,309	380,309		380,309		380,309			33
34	Rent-Facility & Grounds			587,040	587,040		587,040	8,393	595,433			34
35	Rent-Equipment & Vehicles			35,601	35,601		35,601	6,501	42,102			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,278,824	1,278,824		1,278,824	35,963	1,314,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,711	103,101	190,812		190,812	(18,425)	172,387			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		87,711	214,791	302,502		302,502	(18,425)	284,077			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,252,698	450,438	2,653,798	5,356,934		5,356,934	39,211	5,396,145			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,068)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(902)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(19,376)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,297)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(35,381)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,174)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	128,385		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 128,385		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 39,211		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

IMPERIAL OF HAZEL CREST

ID# 0040402

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (2,162)	6	1
2	MARKETING	(33,219)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,381)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	2,578	0	0	0	0	0	0	0	0	2,578	1
2	Food Purchase	(902)	0	0	0	0	0	0	0	0	0	0	(902)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	175	0	0	0	0	0	0	0	0	175	5
6	Maintenance	(2,162)	0	6,847	0	0	0	0	0	0	0	0	4,685	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,064)	0	9,600	0	0	0	0	0	0	0	0	6,536	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	24,891	0	0	0	0	0	0	0	0	24,891	10
10a	Therapy	0	(8,691)	6,712	0	0	0	0	0	0	0	0	(1,979)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(8,691)	31,603	0	0	0	0	0	0	0	0	22,912	16
	C. General Administration													
17	Administrative	0	0	54,246	0	0	0	0	0	0	0	0	54,246	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(10,975)	0	0	0	0	0	0	0	0	(10,975)	19
20	Fees, Subscriptions & Promotions	(6,447)	0	4,288	0	0	0	0	0	0	0	0	(2,159)	20
21	Clerical & General Office Expenses	(52,595)	0	(38,793)	0	0	0	0	0	0	0	0	(91,388)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	732	0	0	0	0	0	0	0	0	732	23
24	Travel and Seminar	0	0	657	0	0	0	0	0	0	0	0	657	24
25	Other Admin. Staff Transportation	0	0	2,440	0	0	0	0	0	0	0	0	2,440	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,545	0	0	0	0	0	0	0	0	2,545	26
27	Other (specify):*	0	0	36,127	0	0	0	0	0	0	0	0	36,127	27
28	**TOTAL General Administration**	(59,042)	0	51,267	0	0	0	0	0	0	0	0	(7,775)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(62,106)	(8,691)	92,470	0	0	0	0	0	0	0	0	21,673	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(27,068)	0	9,853	0	0	0	0	0	0	0	0	(17,215)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	38,284	0	0	0	0	0	0	0	0	38,284	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,393	0	0	0	0	0	0	0	0	8,393	34
35	Rent-Equipment & Vehicles	0	0	6,501	0	0	0	0	0	0	0	0	6,501	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(27,068)	0	63,031	0	0	0	0	0	0	0	0	35,963	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(18,425)	0	0	0	0	0	0	0	0	0	(18,425)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(18,425)	0	0	0	0	0	0	0	0	0	(18,425)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,174)	(27,116)	155,501	0	0	0	0	0	0	0	0	39,211	45

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGT.	NILES	MGMT/CLERICAL
				CAREPLUS REHAB	NILES	THERAPY
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10A	THERAPY SERVICES	$ 48,633	CAREPLUS REHABILITATIVE SERVICES		$ 39,942	$ (8,691)	1
2	V	39	ANCILLARY THERAPY	103,100			84,675	(18,425)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 151,733			$ 124,617	$ * (27,116)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONSULT. FEES	$ 7,200	CAREPLUS MGMT, INC.		$	$ (7,200)	15
16	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	16
17	V	21	CLERICAL FEES	122,400	" "			(122,400)	17
18	V	1	DIETARY SALARIES		" "		9,778	9,778	18
19	V	5	ELECTRICITY		" "		175	175	19
20	V	6	MAINT & REPAIRS		" "		299	299	20
21	V	6	MAINTENANCE SALARIES		" "		6,548	6,548	21
22	V	10	NURSING SALARIES		" "		24,891	24,891	22
23	V	10A	THERAPY SALARIES		" "		6,712	6,712	23
24	V	17	ADMIN. SALARIES		" "		54,246	54,246	24
25	V	19	PROFESSIONAL FEES		" "		3,425	3,425	25
26	V	20	ADVERTISING		" "		4,288	4,288	26
27	V	21	TOTAL OFFICE		" "		21,494	21,494	27
28	V	21	CLERICAL SALARIES		" "		62,113	62,113	28
29	V	23	SEMINARS		" "		732	732	29
30	V	24	TRAVEL		" "		657	657	30
31	V	25	TRANSPORTATION		" "		2,440	2,440	31
32	V	26	INSURANCE		" "		2,545	2,545	32
33	V	27	EMPLOYEE BENEFITS		" "		36,127	36,127	33
34	V	30	DEPRECIATION (SL)		" "		9,853	9,853	34
35	V	32	INTEREST		" "		38,284	38,284	35
36	V	34	OFFICE RENT		" "		8,393	8,393	36
37	V	35	EQUIPMENT RENT		" "		6,501	6,501	37
38	V				" "				38
39	Total			$ 144,000			$ 299,501	$ * 155,501	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATION:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN,FINANC	33.82	SEE ATTACHED	4.9	8.09	SALARY	14,961	17-7	2
3	JACOB BAKST	DIR OPERATIONS	ADMIN, CONS	33.82	SCHEDULE	4.9	8.09	SALARY	14,961	17-7	3
4	ROMY MACASET	RN CONSULT	RN CONSULT	0.49		4.9	8.09	SALARY	7,307	10-7	4
5	JAMMEE O'BRIEN	REGIONAL MGR	ADMINISTRAT	0.49		4.9	8.09	SALARY	10,822	17-7	5
6	JOE ANN BREW	REGIONAL MGR	ADMINISTRAT	0.49		4.9	8.09	SALARY	5,247	17-7	6
7	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.98		4.9	8.09	SALARY	4,638	21-7	7
8	JOE ZIMMERMAN	CFO	FINANCIAL	0.98		4.9	8.09	SALARY	11,305	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,241		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	568,908	9	$ 96,016	$ 96,016	46,007	$ 9,778	1
2	5	ELECTRICITY	CENSUS DAYS	568,908	13	2,165		46,007	175	2
3	6	MAINT & REPAIRS	CENSUS DAYS	568,908	13	3,701		46,007	299	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	568,908	13	80,966	80,966	46,007	6,548	4
5	10	NURSING SALARIES	CENSUS DAYS	568,908	13	307,794	307,794	46,007	24,891	5
6	10A	THERAPY SALARIES	CENSUS DAYS	568,908	13	82,996	82,996	46,007	6,712	6
7	17	ADMIN. SALARIES	CENSUS DAYS	568,908	13	670,787	670,787	46,007	54,246	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	568,908	13	42,352		46,007	3,425	8
9	20	ADVERTISING	CENSUS DAYS	568,908	13	53,021		46,007	4,288	9
10	21	TOTAL OFFICE	CENSUS DAYS	568,908	13	265,794		46,007	21,494	10
11	21	CLERICAL SALARIES	CENSUS DAYS	568,908	13	768,069	768,069	46,007	62,113	11
12	23	SEMINARS	CENSUS DAYS	568,908	13	9,053		46,007	732	12
13	24	TRAVEL	CENSUS DAYS	568,908	13	8,124		46,007	657	13
14	25	TRANSPORTATION	CENSUS DAYS	568,908	13	30,176		46,007	2,440	14
15	26	INSURANCE	CENSUS DAYS	568,908	13	31,470		46,007	2,545	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	568,908	13	446,737		46,007	36,127	16
17	30	DEPRECIATION (SL)	CENSUS DAYS	568,908	13	121,842		46,007	9,853	17
18	32	INTEREST	CENSUS DAYS	568,908	13	473,414		46,007	38,284	18
19	34	OFFICE RENT	CENSUS DAYS	568,908	13	103,790		46,007	8,393	19
20	35	EQUIPMENT RENT	CENSUS DAYS	568,908	13	80,391		46,007	6,501	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,678,658	$ 2,006,628		$ 299,501	25

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIB BANK		X	CAPITAL IMPROVEMENTS	$6,635.09	02/01	$ 315,000	$ 149,260	02/06	PRIME+	$ 14,660	1
2	LOAN COST		X	LOAN COST	W/O OVER 5 YEARS		1,575	682	02/06		315	2
3												3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC.	X		WORKING CAPITAL	DEMAND	04/95	750,000	4,095,000	PRIME+		208,010	6
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING							1,612	7
8	CAREPLUS MGMT ALLOCATION										38,284	8
9	TOTAL Facility Related				$6,635.09		$ 1,066,575	$ 4,244,942			$ 262,881	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,066,575	$ 4,244,942			$ 262,881	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 514,760	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 445,308	2
3. Under or (over) accrual (line 2 minus line 1).		$ (69,452)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 449,761	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 380,309	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	483,360	8
	1999	466,483	9
	2000	492,846	10
	2001	509,663	11
	2002	445,308	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME IMPERIAL OF HAZEL CREST COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040402

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-26-402-004-0000	NURSING HOME	$ 445,307.80	$ 445,307.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 445,307.80	$ 445,307.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,625		$	1
2					2
3	TOTALS	75,625		$	3

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	24,011	616	39	616		6,419	9
10	LEASEHOLD IMPROVEMENTS			1994	37,537	962	39	962		9,305	10
11	ROOF A/C			1995	13,585	348	39	348		2,856	11
12	PARKING LOT			1995	30,285	2,019	15	2,019		17,167	12
13	ELEVATOR REPAIR			1996	7,266	186	39	186		1,481	13
14	WALK-IN FREEZER			1996	12,889	331	39	331		2,419	14
15	STAIRWAY HEATING			1996	3,154	81	39	81		577	15
16	DUCTWORK			1997	7,300	187	39	187		1,286	16
17	ROOFING			1997	2,701	69	39	69		469	17
18	ALARM SYSTEM & DUCTWORK			1997	7,969	204	39	204		1,369	18
19	FLOOR TILE			1997	13,271	340	39	340		2,168	19
20	FLOOR TILE & DUCTWORK			1997	26,700	685	39	685		4,310	20
21	ROOFTOP HEAT/AC			1997	8,512	219	39	219		1,355	21
22	ELECTRICAL REPAIRS			1998	2,600	67	39	67		388	22
23	CARPETING			1998	2,522	65	39	65		371	23
24	REPLACE KITCHEN DRAIN/ STEEL DOORS			1998	6,851	175	39	175		989	24
25	DUCTWORK/DAMPERS/DECORATING/ROOF A/C			1999	33,881	869	39	869		3,854	25
26	ROOF TOP HEATING			1999	8,302	213	39	213		861	26
27	NEW FLOORING			2000	24,624	895	27.5	895		3,170	27
28	ROOF RENOVATION			2000	72,542	2,638	27.5	2,638		8,684	28
29	ROOF TOP UNIT REPAIR			2000	5,261	191	27.5	191		597	29
30	DRAPES UNLINED			2000	1,004	125	20	50	(75)	200	30
31	LINEN BATON DRAW DRAPERY WITH HARDWARE			2001	21,496	4,127	20	1,075	(3,052)	3,225	31
32	PASSENGER ELEVATOR-INSTALL DETECTOR EDGE			2001	2,195	80	27.5	80		190	32
33	INSTALLED NEW HEAT EXCHANGER			2001	1,476	54	27.5	54		115	33
34	REPLACE THE ELEVATOR PUMPING UNIT			2002	4,400	160	27.5	160		287	34
35	REPLACE FIRE ALARM PANEL			2002	7,559	275	27.5	275		309	35
36	FENCE			2003	5,500	244	15	244		244	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALLED NEW FITTING	2003	$ 2,019	$ 52	27.5	$ 52	$	$ 52	37
38	INSTALLED SMOKE DAMPERS	2003	8,213	211	27.5	211		211	38
39	INSTALLED NEW PHONE INSIDE OF ELEVATOR	2003	2,674	69	27.5	69		69	39
40	ELECTRICAL WORK	2003	4,538	117	27.5	117		117	40
41	INSTALLED NEW FROOF DRAIN	2003	3,200	34	27.5	34		34	41
42	PLUMBING WORK	2003	5,360	57	27.5	57		57	42
43	REPLACE ROOF TOP UNIT	2003	5,750	61	27.5	61		61	43
44	PAINTIN AND WALLPAPER BOARDERS	2003	2,890	578	20	145	(433)	145	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	CAREPLUS MGMT INC: LEASEHOLD IMPROVEMENTS			95		95			57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 430,037	$ 17,699		$ 14,139	$ (3,560)	$ 75,411	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 99,174	$ 5,012	$ 7,717	$ 2,705	3-15	$ 51,363	71
72	Current Year Purchases	49,603	28,661	2,448	(26,213)	10	2,448	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC: SL DEPR		9,758	9,758				74
75	TOTALS	$ 148,777	$ 43,431	$ 19,923	$ (23,508)		$ 53,811	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 578,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,130	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,062	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,068)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 129,222	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF HAZEL CREST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	204	03/01/94	$ 587,040	30		3
4	Additions							4
5								5
6								6
7	TOTAL		204		$ 587,040 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 03/01/94
Ending 02/28/24

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 598,781
13.	/2005	$ 610,757
14.	/2006	$ 622,973

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 27,969 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 CHEVROLET	$ 618.00	$ 7,632	17
18		EXPRESS			18
19					19
20					20
21	TOTAL		$ 618.00	$ 7,632	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 57,880	$		$ 57,880	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,652			1,652	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			43,569			43,569	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				79,610		79,610	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPLIES Other (specify): LAB/RENTAL	39-2 39-2					1,378 6,723		1,378 6,723	13
14	TOTAL			$		$ 103,101	$ 87,711		$ 190,812	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (82,794)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	3,323,414		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,870		6
7	Other Prepaid Expenses	3,760		7
8	Accounts Receivable (owners or related parties)	32,088		8
9	Other(specify): Real Estate Tax Escrow	394,565		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,720,903	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	430,038		15
16	Equipment, at Historical Cost	148,776		16
17	Accumulated Depreciation (book methods)	(204,371)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	489,600		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CAPITAL IMPR LOAN FEES	682		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 864,725	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,585,628	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 550,523	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,478		28
29	Short-Term Notes Payable	5,456,760		29
30	Accrued Salaries Payable	127,285		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,579		31
32	Accrued Real Estate Taxes(Sch.IX-B)	449,761		32
33	Accrued Interest Payable	11,872		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,646,258	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,646,258	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,060,630)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,585,628	$	48

*(See instructions.)

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,720,306)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,720,306)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(340,324)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (340,324)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,060,630)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,005,257	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,005,257	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	11,344	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 11,344	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,016,610	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	963,471	31
32	Health Care	1,697,782	32
33	General Administration	1,114,355	33
	B. Capital Expense		
34	Ownership	1,278,824	34
	C. Ancillary Expense		
35	Special Cost Centers	190,812	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,356,934	40
41	**Income before Income Taxes (line 30 minus line 40)****	(340,324)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (340,324)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,870	2,017	$ 55,949	$ 27.74	1
2	Assistant Director of Nursing	2,102	2,265	63,707	28.13	2
3	Registered Nurses	7,146	7,333	172,033	23.46	3
4	Licensed Practical Nurses	23,536	24,470	474,688	19.40	4
5	Nurse Aides & Orderlies	59,193	62,720	518,027	8.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,354	4,069	38,383	9.43	8
9	Activity Director	1,693	2,109	24,093	11.42	9
10	Activity Assistants	5,603	6,130	43,891	7.16	10
11	Social Service Workers	9,831	10,326	160,671	15.56	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,088	32,212	15.43	13
14	Head Cook	5,966	6,825	69,547	10.19	14
15	Cook Helpers/Assistants	10,022	10,584	74,293	7.02	15
16	Dishwashers					16
17	Maintenance Workers	4,391	4,680	46,638	9.97	17
18	Housekeepers	18,279	19,685	144,568	7.34	18
19	Laundry	5,765	6,302	50,260	7.98	19
20	Administrator	2,062	2,090	59,628	28.53	20
21	Assistant Administrator	3,658	4,024	61,545	15.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,896	12,568	107,058	8.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,972	2,044	22,288	10.90	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,727	1,818	33,219	18.27	33
34	TOTAL (lines 1 - 33)	182,105	194,147	$ 2,252,698 *	$ 11.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	1,600	9-3	36
37	Medical Records Consultant	N	1,720	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	20,515	10a-3	43
44	Activity Consultant	E	1,202	11-3	44
45	Social Service Consultant	E	864	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 47,501		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARCITA CARTER	ADMIN	0	$ 59,628
MARTHA RIOS	ASST ADMIN	0	12,847
HELENA MATHEWS	ASST ADMIN	0	48,698
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,173

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT		$
HDSI		
AMERICAN DATA		
NATIONAL DATACARE		
KBKB		
MEYER MAGENCE		
SACHNOFF & WEAVER		
ECONOCARE		
PERSONNEL PLANNERS		
RICHARD PEELO		
		160,871
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 160,871

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,309
Unemployment Compensation Insurance	28,778
FICA Taxes	170,075
Employee Health Insurance	85,850
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,939
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	20,528
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,551
Health Care Worker Background Check	1,308
(Indicate # of checks performed 109)	
MARKETING/ADV/PROMO	6,297
TRUST/FRANCHISE/CONTRIB/ETC	150
LICENSES & PERMITS	4,812
DUES & SUBSCRIPTIONS	11,309
MGMT CO ALLOCATION	4,288
TRUST/FRANCHISE/CONTRIB/ETC	(150)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,297)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	657
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 657

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	07/2003	$ 2,594	3	$	$	$	$ 432	$ 865	$ 865	$ 432	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,594		$	$	$	$ 432	$ 865	$ 865	$ 432	$	$

Facility Name & ID Number IMPERIAL OF HAZEL CREST # 0040402 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11016**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,760** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees